New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061317	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEAL	**2050 SIXTH AVE NEPTUNE CITY, NJ 07753**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments An Initial Approval survey was conducted on 09/26/2024 for the Dialysis Den project. The facility was found to be non-compliant with LTC-LSC regulations.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 12/06/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315105	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	**2050 SIXTH AVE** **NEPTUNE CITY, NJ 07753**

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E 000	Initial Comments This facility was not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006		9/27/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 09/26/2024 in the presence of Facility Management, it was determined that the facility failed to include that the Dialysis Den staff and resident needs were included in the risk assessment and policy and procedures for	E 006	No Residents have been identified to be affected by the deficient practice Dialysis Den staff and Residents have the potential to be affected by the deficient practice	

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E 006	Continued From page 2 Emergency Preparedness in the Long-Term Care (LTC) plan in accordance with Appendix Z. This deficient practice had the potential to affect Dialysis Den staff and residents and was evidenced by the following: At approximately 1:30 PM, a review of the Emergency Preparedness Manual for the Dialysis contracted provider and the Long-Term Care facility revealed there was no inclusion of Dialysis Den staff and residents included in the LTC plan and no reference to the Long-Term Care facility in the Den's plan. In an interview at the time, the facility's US FOIA (b)(6) [redacted] confirmed the findings. NJAC 8:39-31.2(e)	E 006	The plant operations manager was educated on 9/26/2024 on the importance of having a comprehensive emergency preparedness plan that includes Dialysis Den staff and Residents. The emergency preparation plan was updated to include Dialysis Den staff and Residents will be educated before iniation of dialysis den. All Dialysis Den staff will receive education on the facility emergency preparedness plan. facility staff educated on facility emergency preparedness plan on 9/27/24 to include dialysis den to follow facility emergency preparedness plan. Will be reeduate upon iniation of dialysis den Addendum to appendix z was added to EP plan on 9/29/24 to reflect dialysis den will follow Coral Harbor EP plan. upon iniation of dialysis den, the administrator will review the Emergeny prepardness plan binder and effectiveness monthly x3 months. Findings will be presented monthly at monthly QAPI meetings.	
K 000	INITIAL COMMENTS Dialysis Den Project Survey A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/26/24 was found to be in noncompliance with the requirements for participation in	K 000		

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	315105	A. BUILDING **01** B. WING _____	**09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 3 Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Coral Harbor Rehabilitation and Healthcare Center renovated the business office on the 2nd floor to a Dialysis Den for inpatient services.	K 000		
K 252 SS=D	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on interview and observation in the presence of facility staff on 09/26/24, it was determined that the facility failed to ensure that exits did not pass through an intervening room in accordance with NFPA 101: 2012 Edition, Sections 7.4 and 7.5 and 19.2.5.4. This deficient practice had the potential to affect residents on the 2nd floor and Dialysis Den and was evidenced by the following: Observations of the 2nd floor Dialysis Den project area at 12:10 PM, revealed the Den exited to the Long-Term Care unit exit corridor. There were 2	K 252	" The facility failed to ensure that exits did not pass through an intervening room in accordance with NFPA 101: 2012 Edition, Sections 7.4 and 7.5 and 19.2.5.4. Residents on the 2nd floor and Dialysis Den have the potential to be affected. The illuminated exit sign located at the pair of smoke-limiting corridor doors leading to the Dining Room was removed by The facility's Maintenance Director	2/26/25

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K 252	Continued From page 4 designated paths of egress from the corridor with illuminated exit directional signs. One was to an exit stairway in the corridor and the 2nd was into an enclosed dining room that contained an exit stairway. There were no markings to indicate a path of travel through the dining room and there was no fire rated assembly to qualify the separation as a horizontal exit. The dining room area was also noted to have been renovated to accommodate a staff lounge and staff bathroom. In an interview at the time, the facility's US FOIA (b)(6) [redacted] confirmed the findings. NJAC 8:39-31.2(e)	K 252	complete on 2/26/25. By removing the exit sign, the path of egress will no longer be misidentified, ensuring compliance with NFPA 101 regulations. The existing dead-end corridor will remain as-is, in accordance with NFPA 101: 2012 Edition Section 19.2.5.2, as it is impractical and unfeasible to alter the current structure. picture attached The facility□s Safety Committee will conduct quarterly Life Safety Code audits to ensure continued compliance with NFPA 101 requirements. Any future renovations or modifications will be reviewed by a certified Life Safety Code consultant to prevent recurrence of similar deficiencies. The Administrator will review all audit reports and take immediate corrective action if discrepancies are noted. These results and finding will be presented to the facilities monthly at monthly QAPI meeting for three months and ongoing if QAPI team deemed necessary.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315105	A. Building B. Wing	3/11/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0006 Reg. # 483.73(a)(1)-(2) LSC	Correction Completed 09/27/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
9/26/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315105 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	3/11/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0252	Correction Completed 02/26/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/26/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**